IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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March 28, 2008

Joseph Morris
Kootenai Medical Center
2003 Lincoln Way
Coeur d'Alene, Idaho 83814

RE: Kootenai Medical Center, Provider #130049

Dear Mr. Morris:

This is to advise you of the findings of the Medicare Validation survey of Kootenai Medical Center, which was done on March 13, 2008.

Enclosed are Statement of Deficiencies/Plan of Correction forms, CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. Although the hospital is under no obligation to provide a plan of correction for Medicare deficiencies, a plan of correction must be completed regarding State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page. Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **April 10, 2008.** Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call (208)334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130049	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOOTENAI MEDICAL CENTER	2003 LINCOLN WAY COEUR D'ALENE, ID 83814

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A 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification and validation survey of your hospital. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Patricia O'Hara, RN, HFS AED = Automated External Defibrillator JCHO = Joint Commission IV = Intravenous IVP =Intravenous Push	A 000	RECEIVED APR 11 2008 FACILITY STANDARDS	
A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING Performance improvement activities must track medical errors and adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. This STANDARD is not met as evidenced by: Based on review of quality improvement documents and staff interview, it was determined the hospital failed to analyze the causes of medical errors and adverse patient events and failed to implement preventive actions to prevent these adverse events from recurring. The	A 288	A new system + process is underway in automating the incident/occurrence reporting processes that will allow for notification, action, + follow-up. To include monitoring, tracking & trending outcomes Implementation to begin July 1 + projected Completion December 31, 08.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorraine K. Alsheski — TITLE: Director of Patient Safety — (X6) DATE: 4.08.08.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 288	Continued From page 1 hospital did not document the investigation of 8 of 8 potentially serious incidents from 12/07 through 2/08. The findings include: Incident reports for December 2007 as well as January and February 2008 were reviewed. Most of the incidents were minor or beyond the ability of the hospital to influence. Eight incidents were potentially serious and warranted further investigation to ensure other patients would not experience similar events. These included two chemotherapy spills, the failure to infuse ordered blood products, depressed respirations from narcotic use, the inadvertent discontinuance of a chest tube, the failure to remove contraband from a suicidal patient, a toddler who accessed a topical medication, and a confused patient who eloped. Documentation was not present to show these incidents had been investigated. The Director of Patient Safety was interviewed on 3/14/08 at 10:45 AM. She stated six of these incidents had been investigated further but the investigations were not documented. She stated the lack of investigation of incidents had been identified as a concern of the performance improvement department. She said that, at the time of the interview, a system had not been implemented to ensure incidents were investigated and preventative measures were taken. The hospital failed to investigate incidents in order to decrease medical errors and adverse patient events.	A 288		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and	A 450	See BB 284 pg 4 of 8 Plan of Corrections	

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A 450	Continued From page 2 procedures. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview it was determined the hospital failed to ensure that patient medical record entries were timed for 7 of 22 sampled patients (#s 4, 6, 11, 22, 23, 29 and 31), whose records were reviewed. This prevented the hospital from being able to determine a timeline for patient care events. Findings include: 1. Patient #4 was a 41-year-old male admitted on 12/12/07 and discharged 12/20/07. His record showed progress note entries by a dietician on 12/13/08 that was un-timed, by a consulting physician on 12/13/08 that was un-timed, by a pharmacist on 12/17/08 that was un-timed and by a social worker on 12/20/07 that was un-timed. 2. Patient #6 was a 38-year-old female admitted to the hospital on 3/7/08 and was discharged after a short stay on 3/7/08. The patient's record contained a progress note and a post operative note written by physicians and dated 3/7/08. The notes were not timed. 3. Patient #11 was a newborn male admitted 2/6/08 and discharged on 2/8/08. His record showed a progress note entry by a mid-level provider on 2/9/08 that was un-timed. 4. Patient #22 was an 86-year-old male admitted to the hospital on 12/13/07 and discharged on 12/18/07. His record contained progress note entries by physicians on 12/16, 12/17 and 12/18/07 and two entries by RNs on 12/17/07 that were un-timed.	A 450		

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A 450	Continued From page 3 5. Patient #23 was a 60-year-old male admitted to the hospital on 2/5/08 and discharged on 2/9/08. The patient's record contained progress note entries by physicians on 2/6, 2/7, 2/8 and 2/9/08 that were un-timed. 6. Patient #29 was a 79-year-old female admitted to the hospital on 2/22/08 and discharged on 2/29/08. The patient's record contained progress note entries by physicians on 2/22, 2/24, 2/25, 2/26, 2/27 and 2/28 that were un-timed. The patient's record also contained a progress note entry by an Occupational Therapist on 2/25/08 and progress note entries by Speech Therapy on 2/25, 2/27 and 2/29/08 that were un-timed. Further, the patient's record contained progress note entries by Dietary on 2/25, 2/26, 2/27 and 2/29/08 and a single progress note entry on 2/25/08 by Physical Therapy and a single progress note entry on 2/25/08 by Radiology. All of the entries were un-timed. 7. Patient #31 was a 58-year-old male admitted to the hospital on 3/3/08 and was a current patient during the time of the survey. The patient's record contained progress notes dated 3/11 and 3/12/08 from physicians. The progress notes were dated but not timed. 8. On 3/11/08 at 2:50 PM, the hospital's Patient Safety Officer stated she was unaware that Dietary, Respiratory Therapy, Speech Therapy, Physical Therapy, Radiology, Occupational Therapy and Neurology had to write the time of their entry on progress notes. 9. Refer to A454 as it relates to the failure of physicians to time and/or date the authentication	A 450	Clarification: The Director of Patient Safety was aware of the interpretation of the standard at the time of the survey. The statement was made re: electronic entry vs. manual entry in that Staff was not following policy & standard intent.	

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A 450	Continued From page 4 of verbal orders. The hospital failed to ensure progress notes and orders were complete.	A 450		
A 454	482.24(c)(1) ORDERS DATED AND SIGNED (i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section. (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to write orders by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined the hospital failed to ensure that orders, including verbal orders, were dated and timed at the time of authentication for 7 of 22 patients (#s 4, 6, 11, 23, 29, 31 and 33), whose records were reviewed for standards of medical orders. This prevented the hospital from knowing when orders were authenticated. Findings include: 1. Patient #4 was a 41 year old male admitted on 12/12/07 and discharged on 12/20/07. The patient's record contained verbal orders that were authenticated but without time and date as follows:	A 454	See BB 284 pg 4 of 8 Plan of Corrections	

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A 454	Continued From page 5 four orders on 12/13/08 one one order on 12/14/08 one order on 12/15/08 one order on 12/19/08. 2. Patient #6 was a 38-year-old female admitted to the hospital on 3/7/08 and was discharged after a short stay on 3/7/08. The patient's record contained written physician operative orders and admission/transfer orders that were not dated or timed by the physician. 3. Patient #11 was a newborn male admitted on 2/6/08 and discharged on 2/8/08. The patient's record contained verbal orders that were authenticated but without time and date as follows: one order on 2/8/08 one order, date unknown due to lack of documentation. 4. Patient #23 was a 60-year-old male admitted to the hospital on 2/5/08 and discharged on 2/9/08. The patient's record contained 2 sets of verbal physician orders dated 2/5/08 and 2/6/08. The verbal orders were authenticated by the physician but the authentication did not include the date and time. Further, the patient's record contained written physician orders dated 2/5/08, 2/6/08 and 2/9/08. The orders were dated but not timed. 5. Patient #29 was a 79-year-old female admitted to the hospital on 2/22/08 and discharged on 2/29/08. The patient's record contained 4 verbal physician orders dated 2/22/08, 2 verbal physician orders dated 2/23/08, 4 verbal physician orders dated 2/24/08, 2 verbal	A 454		

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A 454	Continued From page 6 physician orders dated 2/25/08, 3 verbal physician orders dated 2/26/08, 4 verbal physician orders dated 2/27/08, 2 verbal physician orders dated 2/28/08 and 1 verbal order dated 2/29/08. The verbal orders were authenticated by the physician but the authentication did not include the date and time. Further, the patient's record contained additional written physician orders dated 2/22/08, 2/23/08, 2/24/08, 2/26/08, 2/27/08, 2/28/08 and 2/29/08. The orders were dated but not timed. 6. Patient #31 was an 58-year-old male admitted to the hospital on 3/3/08. He was a current patient during the time of the survey on 3/12/08. The patient's record contained verbal physician orders dated, 3/9/08 and 3/10/08. The verbal orders were authenticated by the physician but the authentication did not include ~~the~~ the date and time. 7. Patient #33 was an 85-year-old male admitted to the hospital on 3/9/08. He was a current patient during the time of the survey on 3/12/08. The patient's record contained verbal physician orders dated 3/9/08 and 3/10/08. The verbal orders were authenticated by the physician but the authentication did not include the date and time. Further, the patient's record contained additional written physician orders dated, 3/9/08, 3/10/08 and 3/11/08. The orders were dated but not timed. 8. On 3/11/08 at 2:50 PM, the hospital's Patient Safety Officer stated that the issue of undated, untimed verbal and written orders had been identified by JC. She said the hospital was in the process of implementing a system to address and monitor the problem.	A 454		

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A 454	Continued From page 7 The hospital failed ensure orders were dated and timed.	A 454		
A 457	482.24(c)(1)(iii) VERBAL ORDERS AUTHENTICATED BASED ON LAW All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview it was determined the hospital failed to ensure that verbal orders were authenticated by the physician within 48 hours for 1 of 22 patients (#29), whose records were reviewed for standards of medical orders. This resulted in the orders not being valid. Findings include: 1. Patient #29 was a 79-year-old female admitted to the hospital on 2/22/08 and discharged on 2/29/08. The patient's record contained verbal orders dated 2/22/08, 2/23/08 and 2 verbal orders dated 2/26/08, that were not authenticated by the physician as of 3/13/08. 2. On 3/11/08 at 2:50 AM, the hospital's Patient Safety Officer stated that the problem of authenticating verbal orders had been identified by JC and the hospital was in the process of implementing a system to address and monitor the problem.	A 457	See BB 152 pg 198 Plan of Corrections	

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A 457	Continued From page 8 The hospital failed ensure verbal orders were authenticated.	A 457		
A 502	482.25(b)(2)(i) LOCKED STORAGE AREA All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations and staff interview it was determined the hospital failed to ensure that all drugs and biologicals were kept in a secure and locked area. This made the drugs vulnerable to interference by unauthorized persons. Findings include: 1. On 3/12/08 at 11:12 AM, during a tour of the hospitals ICU department, routine medications were observed to be stored in a non-secure and unlocked area. On a counter, within the unit, near the nursing station, sat a small plastic drawer set labeled with room numbers. Each drawer contained a patient's daily routine medications. Additionally, on the counter itself, laid medicated IV fluids and IVP medications. Further, the cabinet above the counter also contained IV medications for patients. This cabinet was not locked and all of the above medications were accessible to the public and general staff. On 3/12/08 at 11:22 AM, the ICU Departments Manager stated, she had questioned the medications being non-secure but had been told that it was ok to store the medications as is.	A 502	See BB 221 pg 298 Plan of Corrections	

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A 502	Continued From page 9 2. On 3/12/08 at 11:22 AM, the hospital's Patient Safety Officer stated that due to the security of the unit (locked entrance), she did not think that the medications needed to be further locked. However, on 3/13/08 at 9:50 AM, one of the ICU's entrance door was observed to be propped open. Further, medications were observed to be on the counter, in a container, that was labeled "New Medications". 3. On 3/12/08 at 11:45 AM, during a tour of the hospitals Neurological department, a cabinet, in a storage room, containing medicated IV fluids was observed not to be locked. Additionally, the IV fluids were accessible to the public and general staff. On 3/12/08 at 11:48 AM, the department's charge nurse stated that the cabinet had been difficult to lock. She was able to lock the cabinet at that time. 4. On 3/12/08 at 2:30 PM, during a tour of the hospitals CCU department, routine medications were observed to be kept in a non-secure and unlocked area. On a counter, near the nursing station, sat a small plastic drawer set labeled with room numbers. Each drawer contained a patient's daily routine medications. Additionally, on the counter itself, layed medicated IV fluids and IVP medications. Further, the cabinet above the counter, contained IV medications for patients. This cabinet was not locked and all of the above medications were accessible to the public and general staff. On 3/12/08 at 2:31 PM, the department's charge nurse stated that the storage of these medications were a standard practice on the unit. 5. On 3/13/08 at 9:15 AM, during a tour of Radiology, in Ultrasound Room #2, a cabinet	A 502	2.) Clarification: Director of Patient Safety was aware of the interpretation of the standard at the time of the survey & the lack of compliance in following the Medication Safety policy Lock repaired at time of survey Same processes put into place as ICU's. See BB 152 5.) Routinely, the US Room #2 door is closed & locked & not	

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A 502	Continued From page 10 containing medications was not locked and was accessible to the public and general staff. The door to the room was propped open to a hallway that was used by the general public, staff and patients. The hospital failed to ensure medications were appropriately stored.	A 502	accessable to the public At the time of the survey, a patient was being transported from another radiology room to US Room #2. Policy reinforced w/ US staff & transport staff.	3.03.08
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observations and staff interview it was determined the hospital failed to ensure that supplies, and equipment were maintained to ensure an acceptable level of safety and quality. This resulted in the inability of the hospital to ensure the accuracy of laboratory test results. Findings include: 1. On 3/12/08 at 11:12 AM, during a tour of the hospital's ICU department, laboratory blood drawing Vacutainer's lg; purple, blue and green tops, were observed to be expired with dates as late as 1/07 to 2/08. 2. On 3/12/08 at 11:45 AM, during a tour of the	A 724	1.) Nursing departments to conduct an assessment of all lab vacutainers & return any unused to the lab. 2.) Reapprove list of nursing units appropriate to have lab supplies IE. oncology 3.) Designated lab staff to continue to follow developed guidelines Re: ongoing monthly monitoring of all nursing areas looking for unapproved lab supplies	4.01.08 4.01.08 4.01.08

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A 724	Continued From page 11 hospital's Neurological department, laboratory blood drawing Vacutainer's lg; purple, blue and green tops, were observed to be expired with dates as late as 1/07 to 2/08. 3. On 3/12/08 at 2:30 PM, during a tour of the hospital's CCU department, laboratory blood drawing Vacutainer's lg; purple, blue and green tops, were observed to be expired with dates as late as 1/07 to 2/08. 4. On 3/12/08 at 3:40 PM, during a tour of the hospitals Medical department, laboratory blood drawing Vacutainer's 1/08 to 2/08 lg; purple, blue and green tops, were observed to be expired. 5. On 3/13/08 at 10:05 AM, the Laboratory's Director stated that there was a process in place to check all laboratory blood drawing Vacutainer floor stock. He said that several phlebotomists were assigned to check all the stocks of Vacutainer tubes and discard the expired tubes. This was not documented. 6. On 3/12/08 at 4:00 PM, during a tour of the hospital's Out Patient Cancer Center, the department's emergency cart log did not contain a daily AED quality systems check. The department's manager and a staff nurse stated that they did not check the AED on any routine bases to verify if the AED was operational. Further, a portable space heater was observed in a room that did not contain a Hospital Electrical Equipment Safety Check sticker. On 3/12/08 at 4:15 PM, the hospital's Patient Safety Officer stated that all of the hospital's electrical equipment needed to be logged and checked by the Electrical Engineering Department before use.	A 724	4) Rounds will be logged & variances documented on an ongoing basis 5.) Variances will be reported to director of department at the time of the rounds. 6. AED daily log implemented on day of survey. Log kept with equipment & daily checks are assigned. Issue resolved. Portable space heater checked & tagged by engineering on the day of survey Issue resolved.	ongoing ongoing 3.13.08 3.13.08

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	130049	A. BUILDING _____ B. WING _____	03/13/2008

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the state licensure survey of your hospital. Surveyors conducting the on-site visit were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Patricia O'Hara, RN, HFS	B 000	RECEIVED APR 11 2008 FACILITY STANDARDS	
BB152	16.03.14.250.09 Medical Orders 09. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law shall be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders shall contain the name of the person giving the order, the first initial and last name and professional designation of the health care practitioners receiving the order. The order(s) shall be promptly signed or otherwise authenticated by the prescribing practitioner in a timely manner in accordance with the hospital¿s policy. (5-3-03) This Rule is not met as evidenced by: Refer to Federal deficiency A0457, as it relates to the failure the hospital to ensure that verbal orders were authenticated by the physician within a timely manor.	BB152	1.) Policy modified & updated to meet requirements 2.) Implementation plan developed & presented to oversight committee 3.) Education & training plan developed for staff & physicians 4.) Plan implementation to begin 5.) Create data collection tool 6.) % medical records reviewed on each unit daily 7.) HIM conducting random audit post discharge 8.) Monthly summary reports to be submitted to designated Committees for review & action as indicated See next page	2.28.08 2.28.08 3.14.08 4.1.08 3.14.08 3.14.08 4.1.08 Started 4.1.08 & ongoing
BB210	16.03.14.320.09 Dietary Santiation 09. Dietary Sanitation. Sanitary standards for hospitals shall be those found in Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Rules Governing Food Sanitation Standards Food Establishments (UNICODE)". (12-31-91)	BB210		

Bureau of Facility Standards

Lorraine K. Alsheski — Director of Patient Safety — 4.08.08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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BB210	Continued From page 1 This Rule is not met as evidenced by: Based on observation and staff interview, it was determined that the hospital failed to provide sanitary standards in the dietary department. The findings included: During an inspection of the hospital kitchen area on 3/6/08 at 10:30 AM, it was observed that: 1) A test strip used to detect sanitizer showed no concentration level when dipped in the water in the soaking sink used for pots and pans. 2) There were no solution buckets for the sanitizing of counter tops found in the bakery prep area or the cafe prep area. 3) There were no logs kept to verify that appropriate sanitizer concentration was checked on a routine basis in the dishwasher or the solution buckets used to clean counter tops. 4) There was no facility policy referring to the proper use or appropriate concentration of quaternary ammonium solution used for sanitizing purposes throughout the kitchen area. On 3/6/08 at 10:45 AM, the Dietary Manager confirmed these findings.	BB210	1) Corrected at the time of survey 2) ongoing monitoring & coaching established 3) Logs have been posted with ongoing daily monitoring assigned. Education & coaching in place for all staff. 4) Policy has been updated & modified to reflect utilization of logs to monitor ongoing compliance & address location of sanitizer buckets. Awaiting final approval	3.13.08 4.7.08 3.18.08 4.25.08
BB221	16.03.14.330.01 Organization and Supervision 330. PHARMACY SERVICE. The hospital shall provide an organized pharmaceutical service that is administered in accordance with accepted professional principles and appropriate federal, state, and local laws. (10-14-88)	BB221	See next page.	

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BB221	Continued From page 2 01. Organization and Supervision. Pharmacy services shall be under the overall direction of a pharmacist who is licensed in Idaho and is responsible for developing, coordinating, and supervising all pharmaceutical services in the hospital. (10-14-88) a. The director of the pharmaceutical service, whether a full, part-time or a consultant member of the staff, shall be responsible to the chief executive officer or his designee. (10-14-88) b. The pharmacist shall be responsible for the supervision of the hospital drug storage area in which drugs are stored and from which drugs are distributed. (10-14-88) c. If trained pharmacy assistants, pharmacy students, or pharmacy interns are employed, they shall work under the direct supervision of a pharmacist. (10-14-88) d. If the director of the pharmaceutical service is part-time, sufficient time shall be provided by the pharmacist to fulfill the responsibilities of the director of pharmaceutical services. (10-14-88) e. The director of the pharmaceutical service shall be responsible for maintaining records of the transactions of the pharmacy as required by law and as necessary to maintain adequate control and accountability of all drugs. This includes a system of control and records for the requisitioning and dispensing of drugs and supplies to nursing units and to other department/services of the hospital, as well as records of all prescription drugs dispensed to the patient. (10-14-88) f. The pharmacist shall periodically check drugs	BB221	1.) Nursing and pharmacy staff to be retrained on the intent of the Medication Safety policy 2.) ongoing daily monitoring will be conducted by pharmacy staff at the time of medication cart exchange & randomly throughout the day tracking compliance 3.) Tracking reports will be reported to the clinical directors at least weekly w/ action when indicated. 4.) Tracking reports will be submitted monthly to the Medication Safety Committee for review & action if indicated	5.1.08 ongoing beginning 4.1.08 ongoing beginning 4.21.08 ongoing beginning 5.1.08

FORM APPROVED

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BB221	Continued From page 3 and drug records in all locations in the hospital where drugs are stored, including but not limited to nursing stations, emergency rooms, outpatient departments, operating suites. (10-14-88) This Rule is not met as evidenced by: Refer to Federal deficiency A0502 as it relates to the failure of the hospital to ensure that all drugs and biologicals were kept in a secure and locked area.	BB221		
BB284	16.03.14.360.13 Signature on Records 13. Signature on Records. Signatures on medical records shall be noted as follows: (10-14-88) a. Every physician shall sign and date the entries which that physician makes, or directs to be made. (10-14-88) b. A single signature on the face sheet record does not authenticate the entire record. (10-14-88) c. Any person writing in a medical record shall sign his name to enable positive identification by name and title. (10-14-88) d. If initials are used, an identifying signature shall appear on each page. (10-14-88) e. Rubber stamp signatures can be used only by the person whose signature the stamp represents. A signed statement to this effect shall be placed on file with the hospital administrator. (10-14-88) This Rule is not met as evidenced by: Refer to Federal deficiency A0454, as it relates to	BB284	1.) Policy has been updated & modified to meet requirements 2.) Implementation plan developed & presented to oversight committee 3.) Education + training plan developed for staff & physicians 4.) Plan implemented to begin 5.) Create data collection tool 6.) 5% medical records reviewed on each unit daily 7.) HIM conducting random audits post discharge 8.) Monthly summary reports to be submitted to designated committee for review + action as indicated	2.28.08 2.28.08 3.14.08 4.1.08 3.14.08 3.14.08 4.1.08 Started 4.1.08 & ongoing

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BB284	Continued From page 4 the failure the hospital to ensure that all orders, including verbal orders, were dated and timed at the time of authentication. Refer also to A450 as it relates to the lack of dating and timing of progress notes.	BB284		
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88) 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to, the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and (10-14-88)	BB297	Policy reflecting Scope of Services has been developed & going through approval process.	4.30.08

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BB297	Continued From page 5 c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88) g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs, equipment, and supplies; and (10-14-88) i. Policy and supporting procedures involving toxicology; and (10-14-88) j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88) k. Policy involving instructions relative to disclosure of patient information; and (10-14-88) l. A policy for integration of the emergency room into a disaster plan. (10-14-88) This Rule is not met as evidenced by: Based on review of Emergency Department policies and staff interview, it was determined the hospital failed to ensure policies had been developed which defined procedures that can/cannot be performed in the emergency room.	BB297		

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BB297	Continued From page 6 The findings include: A policy defining procedures that can/cannot be performed in the emergency room at the hospital was not present. The Director of Emergency Services was interviewed on 3/13/08 at 9:55 AM. She stated this policy had not been developed.	BB297		
BB526	16.03.14.530.01 Maintenance & Safety 530. MAINTENANCE AND SAFETY. The hospital shall be equipped and maintained to protect the health and safety of the patient, personnel, and visitors. (10-14-88) 01. Maintenance. The hospital shall have a written preventive maintenance program to include at least the following elements: (10-14-88) a. Designation of person responsible for maintaining the hospital; and (10-14-88) b. Written preventive maintenance procedure and appropriate inspection interval shall be made for at least the following: (10-14-88) i. Heating systems; and (10-14-88) ii. Air conditioning/mechanical systems; and (10-14-88) iii. Electrical systems; and (10-14-88) iv. Vacuum systems and gas systems; and (10-14-88) v. All air filters in heating, air conditioning and ventilating systems; and (10-14-88)	BB526	See A724 pg 12 of 12 #6. 482.41(c)(2) Plan of Correction	

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BB526	Continued From page 7 vi. Equipment related directly and indirectly to patient care, and any other equipment. (10-14-88) This Rule is not met as evidenced by: Refer to Federal deficiency A0724 as it relates to the failure the hospital to ensure that supplies and equipment were maintained to ensure an acceptable level of safety and quality.	BB526		